Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHSIDE PAIN RELIEF CENTER 3033 FANNIN ST HOUSTON TX 77004	MFDR Tracking #: M4-10-3027-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Per TWCC Board Rule 134.3000 [sic], durable medical equipment under $500.00 dollars per item do not require pre-authorization."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $495.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The requestor on its bill listed diagnosis codes 718.94 (joint derangement of the hand, not otherwise specified), 718.97 (joint derangement of the ankle, not otherwise specified), and 727.61 (rotator cuff repair). Given this, it is reasonable to construe that the requestor intended the use of the unit to these three body areas. These three diagnosis codes are associated with three different treatment guidelines within ODG: Ankle & Foot,, Forearm Wrist, & Hand, and Shoulder. The Ankle & Foot and the Forearm, Wrist, & Hand guidelines do not address neuromuscular stimulator use. However, the Shoulder guideline does to the extent that neuromuscular stimulators are not recommended. DWC Rule 134.600(p)(12) states, "…treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier…" The carrier in this case did not preauthorize a treatment plan. For these reasons Texas Mutual declined to issue payment absent preauthorization for the stimulator even though the dollar amount for the unit was below $500.00."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/04/2009	HCPCS Code E0745	N/A	$495.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin.Code §134.600 sets out the preauthorization procedures for health care providers.
3. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits 07/29/2009:

   - Denied in accordance with 134.600(p)(12) as the treatment/service is in excess of the Division's treatment guidelines as outlined in the disability management rules effective 5/1/07. Please refer to the disability management rules, Chapter 137 on the Division's website.
   - CAC-197 – Precertification/authorization/notification absent.
   - 930 – Pre-authorization required, reimbursement denied.

   Explanation of benefits 11/18/2009:

   - Denied in accordance with 134.600(p)(12) as the treatment/service is in excess of the Division's treatment guidelines as outlined in the disability management rules effective 5/1/07. Please refer to the disability management rules, Chapter 137 on the Division's website;
   - CAC-197 – Precertification/authorization/notification absent;
   - 930 – Pre-authorization required, reimbursement denied;
   - CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration; and
   - 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the requestor obtain preauthorization as outlined in the disability management rules?
2. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Tex. Admin. Code §134.600(p)(12) treatment and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier requires preauthorization. The Respondent states in their position summary that the ODG does not address the use of a neuromuscular stimulator for the ankle, foot, forearm, wrist and hand and the shoulder guideline does not recommend the neuromuscular stimulator. The Respondent states that they did not preauthorize a treatment plan and the Requestor did not submit such a plan with their request for medical fee dispute resolution; therefore, preauthorization is required.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.03, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	July 30, 2010 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.